347 East 37th Street
New York, New York 10016
212-726-7444

Informed Consent For G.I. procedures

Name: DOB: Age: Date:

1. I hereby authorize Dr. and any assistant(s) he deems necessary, to perform an **ENDOSCOPY WITH POSSIBLE BIOPSY.**

2. I understand this procedure involves the passage of a fiberoptic instrument through the mouth and throat and into the esophagus to allow the physician to visualize the interior of the esophagus, stomach, and duodenum (the upper small intestine). The instrument blows air into the stomach; this expands the folds of tissue and makes it easier for the physician to examine the stomach. If polyps (growths of tissue) are visualized or any other abnormalities are visualized, the physician may take a tissue sample (biopsy) for further analysis.

3. I am aware that if I have an advance directive that it is temporarily suspended while I am at this office-based endoscopy unit. If staff should sustain a blood-borne exposure from my blood or body fluids I consent to having blood drawn for HIV and hepatitis studies. The results will be kept confidential.

4. I have not eaten or drank anything for at least six (6) hours beforehand.

5. Sedative medications will be given intravenously for the endoscopy to minimize discomfort and relax me for the procedure. Right before the procedure, the physician may spray my throat with a numbing agent that may help prevent gagging. These medications may cause localized irritation and/or a drug reaction may occur.

6. RISKS: The risk for complications from this procedure is estimated at 0.1% to 1% and rarely may lead to surgery and/or transfusions. I may feel a temporary soreness in my throat. Possible complications of this procedure include, but are not limited to: Bleeding, tearing or perforation of the esophagus, stomach, or small intestine. Minor bleeding may stop on its own or be controlled with cauterization. Other risks, which can be serious/possibly fatal, include difficulty breathing, pneumonia, heart attack, and stroke. These risks are extremely rare but may occur. I also understand that there are no guarantees regarding the results of this procedure.

7. The procedure takes 5-20 minutes. Because I will be sedated, I will need to rest at the office for 20-60 minutes until the medication wears off enough for it to be safe for me to leave.

8. I understand that I should have an adult accompany me home after the procedure since the pain medication given during the procedure may cause drowsiness, dizziness or otherwise impair my judgment. I will not drive a vehicle or operate machines for up to 12 hours after the procedure.

9. If I have severe abdominal pain, a continuous cough, fever, chills, chest pain, nausea or vomiting after the procedure, I should call Dr. 's office at 212-726-74 or go to the closest Emergency Room.

10. I have been provided Educational materials concerning endoscopy, which I have read and understand. Possible alternatives to this procedure may include an upper gi series and a ct scan.

11. I have advised the physician regarding any special medical conditions, including pregnancy, lung or heart condition and any allergies to any medications. If I have diabetes mellitus and am currently on insulin or take medications that may affect blood clotting, I understand that I should speak with my physician as they may require adjustment before the procedure is performed. Other routine medications may continue to be taken with a small sip of water, at least two hours before the procedure.

I have read and fully understand this consent form and understand I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form.

IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED PROCEDURE OR TREATMENT, OR ANY QUESIONS AS TO THE PROPOSED PROCEDURE OR TREATMENT, ASK YOUR PHYSICIAN NOW, BEFORE SIGNING THE FORM.

Patient Signature: _____ Date: 06/10/2009

PHYSICIAN DECLARATION:

I have explained the contents of this document to the patient and have answered al the patient's questions to the best of my knowledge. I feel the patient has been adequately informed and has consented.

Physician Signature: _____ Date: 06/10/2009